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Cost-Savings Supplement: Reallocation of LME Administrative Expense to Direct Services

North Carolina Department of Health and Human Services, Division of Mental Health, Developmental Disabilities and Substance Abuse Services

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Introduction

The State of North Carolina (State), Department of Health and Human Services (DHHS), Division of Mental Health, Developmental Disabilities and Substance Abuse Services (DMH/DD/SAS), engaged Mercer Government Human Services Consulting (Mercer), part of Mercer Health & Benefits LLC, to conduct an independent evaluation of the 25 Local Management Entities (LMEs). The LMEs are responsible for managing the delivery of mental health (MH), developmental disabilities (DD) and substance abuse services (SAS) in their local communities. Mercer conducted the independent evaluation between December 2007 and March 2008 and reported on the evaluation in a separate report titled "The Evaluation and Performance of Local Management Entities" (Mercer Report).

This supplement to the Mercer Report focuses on administrative cost efficiencies that will result in financial resources becoming available for expansion of direct services and addresses Objective 4 of Mercer's assignment.

Objective 4: ***Assess cost-savings from consolidation of business and non-business functions; prepare three (3) options of analyses: cost-savings from additional LME mergers, cost-savings from consolidation of business functions only and cost-savings from consolidation of both business and non-business functions.***

Successful integration of information technology must be a priority of any system reform or consolidation approach.

To address the need for greater access to a wider range of services, DHHS identified the need to consolidate LME business and non-business functions with the goal of promoting efficiency and increasing the funds available for direct services. While it is possible to identify business and non-business functions that could be consolidated, separating the two sets of functions can be challenging given their necessary degree of integration throughout the LME's management activities. For example, the efficient operations of service management, a key function of the LMEs, requires the availability of effective provider services that match the needs of individuals and families, service management staff trained to facilitate the match, information technology that links service authorizations to the payment of provider claims, and measures trends and outcomes. Integrated clinical and administrative functions offer the optimal opportunity to use data to promote quality and efficiency. If an integrated information technology approach is not feasible in the interim, joint ventures, consolidations or mergers may be an approach to reducing the number of LMEs, providing there is a foundation to support data sharing across management entities.

Approach

Mercer's approach to analysis of potential cost savings centered on the three options for consolidation identified in the previous LME Mercer Report. These options included:

- Option 1: maintain the LME structure with fewer LMEs (20 or less)
- Option 2: develop Regional Management Entities (RMEs) and establish provisions for maintaining limited infrastructure for local systems of care
- Option 3: develop a Statewide Central Management Entity (CME) that consolidates functions for efficiency, but maintains a limited infrastructure for local systems of care

As part of the cost review, DMH/DD/SAS provided Mercer with state fiscal year (SFY) 2007 cost data to analyze LME costs. In addition, Mercer requested and received financial information directly from the LMEs. With these data sources, Mercer was able to conduct cost and statistical reviews of the LMEs. Mercer made adjustments to the administrative and statistical data provided by the LMEs to remove non-operational expense items, such as depreciation expense and various non-administrative expenditures incorrectly reported on some of the reports that were submitted by LMEs. The administrative cost savings presented in this report

exclude non-operational expenditures to ensure an equitable analysis among all LMEs. In addition, the pilot Medicaid waiver program medical and administrative expenditures for Piedmont Behavioral Healthcare were removed from our analysis for consistency purposes and to evaluate all LMEs on a comparative basis. Mercer acknowledges that the LMEs provide some service management functions to Medicaid-eligible individuals (e.g., screening, triage and referral). The findings in this report focus primarily on management of State funds and county contributions, and **not** Medicaid revenues. The time period (SFY 2007) for the data analysis was used to ensure that expenditures reported by the LMEs and DMH/DD/SAS reconciled to the LMEs' audited financial statements.

The Mercer Report on the independent evaluation of the LMEs concluded that savings would be achieved by reducing the number of LMEs. This Cost Supplement Report presents estimates of cost savings attributable to the LME consolidation options discussed in the initial Mercer Report

Summary of findings

- If Option 1, maintain the LME structure with fewer LMEs (20 or less), is chosen, an estimated $29.5 million can be redirected to direct services by limiting LME administrative costs to 15 percent.
- If Option 2, develop RMEs and establish provisions for maintaining limited infrastructure for local systems of care, is chosen, an estimated $48.4 million can be redirected to direct services through consolidation of LMEs.
- If Option 3, develop a statewide CME that consolidates functions for efficiency, but maintains a limited infrastructure for local systems of care, is chosen, there would be significant savings. However, the actual dollar amount cannot be determined without a process for DHHS/DMH/DD/SAS determining the functions of the CME and the scope of delegated responsibilities.

A fuller explanation of the potential administrative savings that could be directed to services follows in the remaining sections of this report.

Mercer also includes five recommendations for financial performance monitoring:

- Conduct independent audits
- Implement quarterly financial reporting requirements
- Implement single-stream funding for all State funds
- Conduct provider audits and data analyses
- Maximize available revenues through increased Coordination of Benefits (COB) and Third Party Liability (TPL) recovery efforts

These recommendations are described more fully in the last section of this report.

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Cost-savings analysis to support options from the Mercer Report

Option 1 Analysis: maintain the LME structure with fewer LMEs (20 or less)

Data received from the LMEs for administrative expenses as a percentage of State-reported total LME expenditures indicate that more than half of the LMEs had administrative expense ratios greater than 19 percent for SFY 2007. Mercer's experience from work with other behavioral health (BH) systems throughout the country has shown that administrative expense ratios normally range between 10 to 15 percent depending on the responsibilities delegated to the BH managed care entities.[1] Thus, Mercer concluded that the administrative costs of the LMEs are high in comparison to other states.

Table 1 on the following page presents the administrative expense ratios for existing LMEs, and reports total and administrative expenditures for SFY 2007.

[1] Mercer works with over thirty-five states on their health and behavioral health care programs.

Table 1 – Comparison of SFY07 LME current administrative expense ratios				
LME	Total adjusted expenditures*	Total adjusted administrative expenditures reported*	Administrative % of total expenditures	General population
Crossroads Behavioral Healthcare	$20,294,291	$4,849,986	23.9%	259,341
East Carolina Behavioral Health	$30,863,250	$4,891,158	15.8%	341,488
Mecklenburg County Area MH DD & SA Authority	$74,172,709	$11,844,647	16.0%	842,622
Mental Health Services of Catawba County	$12,800,562	$3,511,685	27.4%	152,597
Piedmont Behavioral Healthcare	$31,864,971	$4,288,893	13.5%	685,297
Smoky Mountain Center	$15,021,908	$4,007,080	26.7%	352,858
Western Highlands Network	$40,066,561	$4,714,482	11.8%	491,778
Tier one subtotal	$225,084,252	$38,107,931	16.9%	3,125,981
Alamance-Caswell-Rockingham	$23,050,202	$4,281,362	18.6%	258,370
Albemarle MH Center & DD/SAS	$19,873,366	$4,791,163	24.1%	231,925
CenterPoint Human Services	$34,681,146	$8,207,686	23.7%	423,441
Five County Mental Health Authority	$18,950,418	$4,445,839	23.5%	231,946
Foothills Area MH/DD/SA Authority	$13,617,856	$4,228,917	31.1%	249,261
Guilford Center for Behavioral Health and Disability Services	$33,552,596	$7,039,253	21.0%	455,137
Onslow Carteret Behavioral Healthcare Services	$11,596,024	$3,349,473	28.9%	223,377
Orange-Person-Chatham MH/DD/SA Authority	$22,994,933	$4,095,869	17.8%	221,571
Pathways MH/DD/SA	$39,278,741	$5,800,256	14.8%	366,695
Southeastern Center for MH/DD/SAS	$31,228,914	$4,767,412	15.3%	334,637
Southeastern Regional MH/DD/SAS	$23,075,968	$4,580,360	19.8%	256,034
The Beacon Center	$13,396,864	$3,709,867	27.7%	244,632
The Durham Center	$23,900,697	$4,350,902	18.2%	248,516
Tier two subtotal	$309,197,725	$63,648,357	20.6%	3,745,542
Cumberland County Mental Health Center	$22,470,895	$4,592,752	20.4%	307,463
Eastpointe	$20,169,832	$3,166,779	15.7%	294,695
Johnston County Area MH/DD/SA Authority	$9,492,298	$2,227,435	23.5%	155,874
Sandhills Center for MH/DD/SAS	$37,501,490	$7,421,703	19.8%	531,311
Wake County Human Services	$63,775,232	$11,632,085	18.2%	807,934
Tier three subtotal	$153,409,747	$29,040,754	18.9%	2,097,277
Total	**$687,691,724**	**$130,797,042**	**19.0%**	**8,968,800**

* Medicaid dollars removed from analysis. Administration dollars reported directly from LMEs.

If Option 1 is selected, Mercer recommends placing a limit on administrative expenses for each LME, using a percentage of the total expenditures (administrative expense ratio). This percentage range allows for adequate administrative expenses to efficiently run a BH managed care entity, while providing maximum dollars for direct services. If administration is capped at 15 percent for all LMEs, Mercer estimates that administrative cost savings of $29.5 million can be reallocated to direct services. The savings were calculated based on LMEs with administrative expense ratios below 15 percent maintaining their current administrative expense ratio, and those above 15 percent being reduced to the recommended 15 percent cap level. Mercer selected 15 percent instead of 10 percent as the acceptable administrative expense ratio because the LMEs, in addition to managing services for State-funded individuals, also perform certain limited functions for Medicaid-eligible individuals (e.g., some screening and triage, provider relations and care coordination).

If administration is capped at 15 percent for all LMEs, instead of the current average of 19.02 percent, $29.5 million could be reallocated to direct services.

Option 2 Analysis: develop RMEs and establish provisions for maintaining limited infrastructure for local systems of care

A more efficient approach would be to have fewer LMEs that centralize all core business and non-business functions under a unified management structure.

Consolidation of LMEs on a regional basis with county representation would enhance the service delivery system and provide DMH/DD/SAS with more focused oversight to ensure that the management entities are compliant with State policies and are operating at a high level of efficiency. To evaluate the savings estimate, Mercer grouped LMEs by those serving: greater than 10,000 individuals; between 5,000 and 10,000; and less than 5,000. LMEs serving greater than 10,000 individuals are then compared to the average administrative burden observed for LMEs that have served less than 10,000 individuals.

Table 2 illustrates the administrative expense ratios by LME size.

Table 2 — SFY07 administrative differences by LME size			
Cost-savings analysis of LME by population size	Administrative expenses reported*	Count of lives served*	Average administrative dollar per individual served
LMEs > 10,000	$ 40,728,250	103,815	$ 392.32
LMEs 5,000 — 10,000	$ 62,957,604	86,136	$ 730.91
LMEs < 5,000	$ 27,111,187	20,099	$1,348.88
Total	**$130,797,041**	**210,050**	**$ 622.69**
Average LMEs < 10,000	$ 90,068,791	106,235	$ 847.83

*Medicaid expenditures were removed for this analysis. Mercer collected data for administrative expenditures and count of lives served directly from the LMEs.

As can be seen from the "Average SFY 2007 administrative dollar per individual served," there is a direct correlation between LMEs that serve greater than 10,000 individuals and fewer administrative dollars spent per individual served. In order to apply the differences for LME size variations and estimate the administrative cost savings, the average administrative expense per individual served for LMEs > 10,000 would be applied to the remainder of the population served. This methodology assumes that the remaining population for the smaller LMEs serving less than 10,000 would be absorbed by the larger LMEs. Administrative expense ratios using this estimate would be reduced to 12 percent of total expenditures, as calculated in Tables 3 and 4 below.

Table 3 calculates the scenario for RMEs serving greater than 10,000 individuals.

Table 3 – SFY07 RME cost-savings estimate	
Potential cost-savings analysis for LMEs with lives served greater than 10,000 based on SFY 2007 data	
Average administrative cost per person for LMEs serving greater than 10,000 individuals annually	$ 392.32
Average administrative cost per person for LMEs serving less than 10,000 individuals annually	$ 847.83
Potential savings for consolidating LMEs serving less than 10,000 individual annually	$ 455.51
Total LME individuals served	210,050
Less LMEs with greater than 10,000 individuals served	-103,815
LMEs with less than 10,000 individuals served population	106,235
Total estimated savings per individual served applied to less than 10,000 population	**$ 48,391,105**

The difference between the current administrative expense for LMEs serving greater than 10,000 individuals and those serving less than 10,000 individuals is $455.51 per person ($392.32 vs. $847.83 per person, respectively).

When the $455.51 difference is applied to the 106,235 individuals that would be served by RMEs, the result is an estimated $48.4 million in savings.

Consolidation of smaller LMEs into RMEs could result in estimated savings of $48.4 million.

Note: The savings analysis above does not assume that the LMEs currently serving 10,000 or greater lives would be selected for this option. It is presented to show economies-of-scale by limiting the number of LMEs with larger population bases. By using this approach, the administrative expense ratio is reduced to 12 percent when combining smaller LMES to exceed a minimum of 10,000 lives served, as shown in Table 4 below.

Table 4 – SFY07 administrative expense ratio when combining LMEs to a minimum of 10,000 members					
Cost-savings analysis of LME by size	Total adjusted expenditures	Adjusted administrative reported	Percent of administrative to total expenditures	Count of lives served	Average administrative dollar per individual served
All LMEs	$687,691,723	$82,405,937	12.0%	210,050	$392.32

This analysis does not consider specific funding for satellite offices that would be necessary for local representation throughout the State. However, the creation of satellite offices would not, in Mercer's opinion, result in a significant investment on the part of the RMEs. Leasing office space to include utilities is estimated not to exceed more than $5,000 per satellite office per month, excluding personnel requirements. Personnel requirements would be met through shifting required staff and office equipment from the regional office to a satellite office.

Satellite offices would require secure internet connectivity to the RME, which is also included in our estimate of $5,000 per month. For example, if three RMEs were developed in each of three State regions, or a total of nine RMEs were established, approximately 15 satellite offices would be require. Mercer estimates that a total of $900,000 would be required in administration expenditures based on the RME option. In this example, nine RMEs would serve an average of approximately 23,000 individuals. Within the economies-of-scale analysis in Tables 2 through 4 above, Mercer would not reduce the estimate of $48.4 million in savings for the estimated $900,000 in administrative expenses related to the satellite office requirements.

Option 3 Analysis: develop a statewide CME that consolidates functions for efficiency, but maintains a limited infrastructure for local systems of care

The development of a CME model would require a ground-up budget approach to estimate cost savings. If this option is selected, Mercer recommends a competitive procurement process. Estimated savings for business and non-business functions cannot be evaluated without considering the complexity and variety of infrastructure cost components that the State would decide upon in their development of the procurement. Mercer would require detailed information on the design of one central CME model to calculate cost savings for this option. Mercer would expect savings to be similar or potentially greater than the RME option due to the economies-of-scale associated with serving more individuals with fewer entities.

3

Recommendations for financial performance monitoring

The following recommendations focus on the specific requirements of a management entity and its responsibility to ensure fiscal management. These recommendations are based upon Mercer's review of current LME requirements and issues identified throughout Mercer's independent evaluation of the LMEs. Mercer observed opportunities for improvement in oversight and operations during our reviews of LME operations. Mandatory reporting requirements and focused data reviews should be conducted as part of the prudent fiscal oversight and monitoring of the existing, reduced or consolidated LME infrastructure models recommended in the Mercer Report.

Mercer's recommendations identify areas of improvement that DMH/DD/SAS could pursue to ensure more consistent and meaningful financial and utilization reporting requirements from the LMEs.

Conduct independent audits

Although the LMEs do have an annual audit requirement, the county-based LMEs are generally integrated within the overall county Comprehensive Annual Financial Report, along with other public health programs. A more meaningful and consistent auditing requirement is recommended for the county-based audits to include a separate audit and review of internal controls for the county's individually sponsored LME.

Implement quarterly financial reporting requirements

LMEs currently provide DMH/DD/SAS with monthly financial statistical reports and quarterly financial monitoring statements for reporting and review purposes. Mercer recommends enhancing financial reporting requirements, which would allow DMH/DD/SAS to monitor and evaluate utilization, budgets, and the continued viability of the LMEs.

This should include, at a minimum, a standardized reporting package, which includes:

- Balance sheets
- Income statements – to include pre-defined revenue and administrative expenses
- Utilization and individuals served reporting
- Accounts receivable reporting and enhanced budget tracking
- Claims payable reporting to include aging reports
- Coordination of Benefits (COB) with other insurance and Third Party Liability (TPL) reporting

Frequent financial reporting is essential for business monitoring purposes.

These financial reporting requirements are normally observed by Mercer in other states for their monitoring and evaluating of physical and BH care entities.

Implement single-stream funding for all State funds

The State should move towards single-stream funding for all LMEs. As of this report date, eight LMEs have been approved for single-stream funding. In conjunction with the budget estimates, DMH/DD/SAS and the Controller's Office should evaluate estimates as compared to actual results by service category on a monthly basis to determine the accuracy of budgeted expenditure categories to actual service expenditures. Although this is a current practice, LMEs that consistently over- or under-estimate expenditures by category-of-service should be elevated to a higher level of scrutiny through requests for variance explanations, as well as onsite reviews to further evaluate the causes for cost overages. In conjunction with this higher level of scrutiny, LMEs that repeatedly do not submit correct or timely financial reports in compliance with the reporting requirements should submit a corrective action plan and potentially be subjected to deferral of payments until accurate and timely reports are submitted.

Conduct provider audits and data analyses

Claims auditing is an important payer function to ensure provider and program integrity.

LMEs should conduct provider audits and utilization analyses. These are critical for controlling costs related to under- or over-utilization for members in need of BH services. Additional LME analysis performed through administrative oversight agencies and other data analysis could provide a balance between cost controls, the equitable distribution of services and improve integrity and accountability for the State BH programs. All LMEs should be required to implement quality review processes for claims payments. This process should include randomly selecting two to three percent of all processed claims for review. Each LME should also create policies and procedures for performing quality audits and implement a process for tracking and reporting the results.

Maximize available revenues through increased COB and TPL recovery efforts

COB and TPL efforts are critical to ensuring that all insurance benefits are exhausted prior to the expenditure of state and Medicaid funds.

DMH/DD/SAS should require LMEs to improve COB efforts with other carriers when other insurance is available. The LMEs should routinely request, collect and store COB information. In the LME claims processing function, the system should have the ability to stop claims from being paid unless other insurance information has been coordinated when applicable. In addition, the LMEs need to enhance collection efforts subsequent to claim payment, once other insurance has been retroactively identified.

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